Vision Claim Form

Sheet Metal Workers' Local 270 Welfare Fund
1863 N. 105th E. Ave
Tulsa OK 74116
(918) 587-2388

TO BE COMPLETED BY MEMBER:

NAME_____ SS#_____

ADDRESS: _____

CITY: _____STATE: _____ZIP:_____

PATIENT:_____DOB:_____

RELATIONSHIP TO MEMBER (circle one) SELF SPOUSE CHILD

PHONE #: (_____)_____

Are you or any of your dependents cover under any other vision plan? ( ) Yes ( ) No

If yes, please provide Insurance information below.

Name of Insured: _____ ***Insured's D#***_____

Policy or Plan No: _____***Coverage Type: ( ) Individual ( )Family***

Insurance Co: _____***Phone No.(____)***_____

Address: _____

City: _____ ***State:*** _____ ***Zip:*** _____

Members Signature: _____ Date: _____